## **UNITED STATES DISTRICT COURT EASTERN DISTRICT OF PENNSYLVANIA**

Anthony Martle

and

Dion Kendell Brown

Civil Action No. 02-5177

Plaintiffs.

V.

Darius Archibald

and

Nicholas Kempf, Sr.

and

**United States Postal Service** 

Defendants.

**DECLARATION OF** HELEN J.S. WHITE

- I, Helen J.S. White, Attorney, United States Postal Service, make the following declaration in lieu of affidavit pursuant to 28 U.S.C. § 1764. I am aware that this declaration is the legal equivalent of a statement under oath and that it will be filed with the U. S. District Court for the Eastern District of Pennsylvania.
- Nicholas Kempf Sr. was the driver of the government vehicle involved in this incident on September 26, 2001. Mr. Kemp was acting within the scope of his employment at all times relevant to this incident.
- 2. By letter dated October 1, 2001, the Postal Service first received notice from the Law Offices of Samuel Fishman, P.C. that Plaintiffs were allegedly injured in this incident.
- By letter dated May 6, 2002, Attorney Fishman sent a detailed 3. letter to a local Postal employee, Dale W. Sigman, District Accident Tort Claims Administrator, summarizing the alleged facts of the incident with a view toward settlement.
- By letter dated May 8, 2002, Dale W. Sigman, sent to the Law Offices of Samuel Fishman, P.C. a Standard Form 95 ("Claim For Damage, Injury, or Death) explaining the requirements of a valid claim.

GOVERNMENT EXHIBIT

- Dale Sigman received the completed SF 95s from Plaintiffs, 5. Anthony Martle and Dion Brown on May 21, 2002.
  - Plaintiffs' administrative claims have not been adjudicated. 6.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Attorney

**United States Postal Service** 

ilonate

8-22-02 Date

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CLAIM FOR DAN INJURY, OR DE	ATH	INSTRUCTIONS: supply information necessary. See	n requested on reverse side	on both sid for additio	les of this form. nal instructions.	on the reverse sid Use additional sh	eet(s) if	FORM APPROVED OMB NO. 1105-0008
1. Submit To Appropriate Federal A DALE W SIGMAN (US	S POSTAL SE	RVICE)	1 6	See instru	ctions on revers	e.) (Number, stre	et, city, St	resentative, if any. tate and Zip Code)
ACCIDENT/TORT CL/ 1905 OLD PHILADEL			(	Claim		n Kendall		
LANCASTER PA 1766						0 W. Godf ladelphia		Nve, Apt.A
			]	Repre		e: See at		
	1/29/75	5. MARITAL ST S	We	ednes	day, 9/2	6/01	111	E(A.M. OR P.M.) :45 p.m.
Basis of Claim (State in detail the place of occurence and the caus	se thereof) (Use a	dditional pages if i	necessary.)					-
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on reverse side )	t is not						10r 20122	. (Coo Hondoo,
10.			INJURY/WRO					
STATE NATURE AND EXTENT OF E NAME OF INJURED PERSON OR D		CAUSE OF DEA	TH, WHICH F	ORMS TH	E BASIS OF THE	ECLAIM. IF OTH	ER THAN	CLAIMANT, STATE
Cervical Sprairight shoulder subluxation; 1	r sprain/	strain;c	ervical	l spin on.	nal subl	uxation;t	spra horac	in/strain ic spinal
11.			WITNESSES	3	DENT/TORT	D CLAIMS		
NAME				ADDRESS	1.0 1.1	, city, State, and	Zip Code)	
N/A				I A LA No	MAY 4/2 NCASTER D CASTER PA	2002 1STRICT 17602-9302		
12. (See instructions on reverse)		AMOUN	T OF CLAIM	(in dollars)				
12a. PROPERTY DAMAGE	12b. PERSONAL	LINJURY	12c. WRC	ONGFUL D	EATH	12d. TOTAL (Fail		•
N/A	\$50,00	·		N/A	•	<b>★</b> \$50,0	000	
I CERTIFY THAT THE AMOUNT OF AMOUNT IN FULL SATISFACTION A	AND FINAL SETT	LEMENT OF THE	S AND INJURII IS CLAIM	ES CAUSE	D BY THE ACC	IDENT ABOVE AN	ID AGREE	TO ACCEPT SAID
3a. SIGNATURE OF CLAIMANT (S	e instructions on	reverse side.)			13b. Phone nun	nber of signatory		
12/7=					215.636	.0303	5/:	15/02
	Y FOR PRESENTI JLENT CLAIM to the United State		GOVERN		CLAIM OR MA	Y FOR PRESENTII AKING FALSE ST. 30 or imprisonmen	ATEMENT	S

95-109 Previous editions not usable.

(See 31 U.S.C. 3729.)

STANDARD FORM 95 (Rev. 7-85) PRESCRIBED BY DEPT. OF JUSTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached. A. Authority: The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 501 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

B. Principal Purpose: The information requested is to be used in evaluating claims.

C. Routine Use: See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.

D. Effect of Failure to Respond: Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid".

### INSTRUCTIONS

Complete all Items - insert the word NONE where applicable

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY DAMAGES IN A SUM CERTAIN FOR INJURY TO OR LOSS OF

Any instructions or information necessary in the preparation of your claim will be turnished, upon request, by the office indicated in Item #1 on the reverse side. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplemental regulations also. If more than one agency is involved, please state each agency.

The claim may be filed by a duly authorized agent or other legal representative. provided evidence satisfactory to the Government is submitted with said claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file claim for both personal injury and property damage, claim for both must be shown in item 12 of this form.

The amount claimed should be substantiated by competent evidence as follows: (a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.

PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN TWO YEARS AFTER THE CLAIM ACCRUES.

(b) In support of claims for damage to property which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.

(c) In support of claims for damage to property which is not economically repairable. or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familier with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.

(d) Failure to completely execute this form or to supply the requested material within two years from the date the allegations accrued may render your claim "invalid". A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

Fallure to specify a sum certain will result in invalid presentation of your claim and may result in forfeiture of your rights.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden,

to Director, Torts Branch Civil Division

Office of Management and Budget ork Reduction Project (1105-0008)

Civil Division U.S. Department of Justice		Paperwork Reduction Project (1105-0008) Washington, DC 20503				
Washington, DC 20530		INSURANCE COVERAGE sential that the claimant provide the following information regarding the insurance coverage of his vehicle or property.  No				
	to distincted it is seen		- to the continue record	ing the insurance coverage of his venicle or property.		
order that subrogation claims may	y be adjudicated, it is esse	and address of insuran	ce company (Number, street, city.	State, and Zip Code) and policy number. XLI No		
5. Do you carry accident insurance	e? 🖸 Yes, nyes, gave n	Mile Bid Socies of Biographic		, State, and Zip Code) and policy number. XQ No		
No.						
NO.	* ,					
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			15102	17. If deductible, state amount		
8. Have you filed claim on your in	surance carrier in this inst	ance, and if so, is it full cov	erage of deductioner			
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	and the section has	your insurer taken or propo	ses to take with reference to your	claim? (It is necessary that you ascertain these fact		
8. If claim has been filed with you	TI. CELLIEL MISST SCHOOL 1999	,				
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		. 5 V. H	name and address of insurance ca	mer (Number, street, city, State, and Zip Code)		
19. Do you carry public liability as	nd property damage insura	nce? 🖽 Yes, II yes, give i		mier (Number, street, city, State, and Zip Code)		
N/A				The second of th		
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12- 110A

CLAIM	FO	PRD	)AMAGE,	
INJUR	Υ,	OR	DEATH	

INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.

FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:

DALE W SIGMAN (US POSTAL SERVICE) ACCIDENT/TORT CLAIMS 1905 OLD PHILADELPHIA PIKE

LANCASTER PA 17602-9302

2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, street, city, State and Zip Code)

Claimant: Anthony Martle

5833 N. 15th Street

Phila, PA 19141

Representative: see attached.

3. TYPE OF EMPLOYMENT 4. DATE OF BIRTH □ MILITARY ST CIVILLAN

4/22/64

S

5. MARITAL STATUS 6. DATE AND DAY OF ACCIDENT Wed. 9/26/01

7. TIME (A.M. OR P.M.) 11:45 p.m.

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurence and the cause thereof) (Use additional pages if necessary.)

On Wednesday, September 26, 2001, at approximately 11:45 p.m., claimant was a front seat passenger in a vehicle driven by Darius Archibald, that was traveling eastbound on I-76 when a USPS truck driven by Nicholas Kempf suddenly crossed lanes and sideswiped the right passenger side of the vehicle, causing severe property damage from right rear door to the bumper.

Claimant complained of back, neck, and shoulder pain immediately. Claimant was treated at Hahnemann University Hospital and Tabor Chiropractic Center. See below for injuries sustained.

9.

### PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, street, city, State, and Zip Code)

Darius Archibald, 2122 Magee Ave, Phila, PA 19149

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

Claimant is not making a claim for property damage.

10.

11.

### PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

cervical sprain/strain; thoracic sprain/strain; lumbosacral sprain/ strain; bilateral shoulder sprain/strain, cervical spinal subluxation; thoracic spinal subluxation; lumbar spinal subluxation.

# ACCHESE ST/TORT CLAIMS

RECOMBSS & Number, street, city, State, and Zip Code)

N/A

I ANCASTER DISTRICT LANCASTER PA 17602-9302

12. (See instructions on reverse)

N/A

AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE

12b. PERSONAL INJURY

\$ 50,000

12c. WRONGFUL DEATH N/A

12d. TOTAL (Failure to specify may cause forfeiture of your rights.)

\$50,000

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE ACCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

3a. SIGNATURE OF CLAIMANT (See Instructions on reverse side.)

NAME

GOVERNMENT

EXHIBIT

215.636.0303

13b. Phone number of signatory 14. DATE OF CLAIM 5/15/02

CIVIL PENALTY FOR PRESENTING

FRAUDULENT CLAIM

The claimant shall forfeit and pay to the United States the sur plus double the amount of damages sustained by the United St (See 31 U.S.C. 3729.)

NSN 7540-00

MINAL PENALTY FOR PRESENTING FRAUDULENT **CLAIM OR MAKING FALSE STATEMENTS** 

ore than \$10,000 or imprisonment for not more than 5 years

18 U.S.C. 287, 1001.)

:5-109

revious editions not usable.

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to Director, Torts Branch Civil Division

and to the Office of Management and Budget

Civil Division U.S. Department of Justice		Office of Management and Bodget Paperwork Reduction Project (1105-0008) Washington, DC 20503		
Washington, DC 20530		INSURANCE COVERAGE	and a superpose of his vehicle or property	
	he adjusticated it is essential that the ci-	simant provide the following information regards	ng the insurance coverage of his vehicle or property State, and Zip Code) and policy number. x. No	
order that subrogation claims may t	De statute to a serie and addre	ss of insurance company (Number, street, city,	State, and Zip Code) and posicy number. 322 140	
5. Do you carry accident insurance?	? [] Yes, if yes, give italie and accept		State, and Zip Code) and policy number. 🔀 No	
No.				
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8. Have you filed claim on your inst	urance carrier in this instance, and if so,	, is it full coverage or decomme		
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N/A				
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	had notice her ways insurer tal	on or proposes to take with reference to your	claim? (It is necessary that you ascertain these fact	
8. If claim has been filed with your	Carner, what accon has you assure as		claim? (It is necessary that you ascertain these fact	
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14, 11	•			
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